

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.
791 Dr. H. H. H. H.

1. PLACE OF DEATH
39 County Greene Registration District No. 918
3 Township _____ Primary Registration District No. 2001
5 City Springfield Mo. 428 S. Main St. _____ Ward _____
2. FULL NAME Jennie Ghan
(a) Residence. No. 428 S. Main St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF T. A. Ghan
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 26 - 1861
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 2 2
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home 72A
(b) General nature of industry, business, or establishment in which employed (or employer) 71B
(c) Name of employer 169

9. BIRTHPLACE (CITY OR TOWN) 2
(STATE OR COUNTRY) Tennessee
10. NAME OF FATHER Hugh Guthrie
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tennessee
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Martha Harmon
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tennessee
(STATE OR COUNTRY)

14. INFORMANT T. A. Ghan
(Address) 428 S. Main
15. FILED 1-31-1932 Hon. Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-29 1932
17. I HEREBY CERTIFY That I attended deceased from Dec 15 1930 to Jan 29 1932
that I last saw her alive on Jan 28 1932, and that death occurred, on the date stated above, at 1:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Splenomegaly, leukemia
7 1/2 yrs. (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Secondary anemia
exhaustion (duration) yrs. 2 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? to DATE OF 1
WAS THERE AN AUTOPSY? 1
WHAT TEST CONFIRMED DIAGNOSIS Robert H. H. H. M. D.
(Signed) _____
(Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greensburg DATE OF BURIAL Jan 31 1932
UNDERTAKER Oliver Lafayette ADDRESS 534 St
General Home Louis

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 24 1932

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